STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	151547	A. BUILDING _____ B. WING _____	R 03/15/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HANCOCK MEMORIAL HOSPICE	**1560B STATE ST GREENFIELD, IN 46140**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{S 000}	INITIAL COMMENTS This visit was a revisit for a state licensure survey and addition of an inpatient hospice center on February 1, 2012. Date: March 15, 2012 Facility #: 9173 Medicaid #: 200192200A Surveyor: Susan E. Sparks, RN Public Health Nurse Surveyor Three Conditions of Participation and 22 standard level deficiencies were found corrected. Hancock Memorial Hospice is in compliance with IC 16-25-3 and the Conditions of Participation 42 CFR 418. Quality Review: Joyce Elder, MSN, BSN, RN March 16, 2012	{S 000}		